Please read the instructions before completing this form

Servicemembers' Group Life Insurance Election and Certificate

Use this form to: (check all that apply)

- ☐ Name or update your beneficiary
- ☐ Reduce the amount of your insurance coverage
- ☐ Decline insurance coverage

Important: This form is for use by Active Duty and Reserve members. This form does not apply to and cannot be used for any other Government Life Insurance.

Last name	First name	Middle name	Rank, title or grade	Social Security Number
DOE	STEPHEN	M	PFC	123456782

Branch of Service(Do not abbreviate)	Current Duty Location
Army	WAA5E0

Amount of Insurance

By law, you are automatically insured for $400,000. ***If you want $400,000 of insurance,*** skip to Beneficiary(ies) and Payment Options. ***If you want less than $400,000*** of insurance, please check the appropriate block below and write the amount desired and your initials.Coverage is available in increments of $50,000. ***If you do not want any insurance*,*** check the appropriate block below and write (in your own handwriting), "I do not want insurance at this time."

Declining SGLI coverage also cancels all family coverage under the SGLI program.

☐ I want coverage in the amount of $ _____ Your initials_____

☐ _____

(Write "I do not want Insurance at this time.")

****Note:*** Reduced or refused insurance can *only* be restored by completing form SGLV 8285 with proof of good health and compliance with other requirements. Reduced or refused insurance will also affect the amount of VGLI you can convert to upon separation from service.

Beneficiary(ies) and Payment Options

I designate the following beneficiary(ies) to receive payment of my insurance proceeds. I understand that the principal beneficiary(ies) will receive payment upon my death. If all principal beneficiaries predecease me, the insurance will be paid to the contingent beneficiary(ies).

Complete Name (first, middle, last) and Address of each beneficiary	Social Security Number (If known)	Relationship to you	Share to each beneficiary (Use %, $ amounts or fractions)	Payment Option (Lump sum or 36 equal monthly payments)
Principal				
1. SANDRA DOE 2034 DARLEN AVE. APT 201A HINESVILLES GA US 54321		WIFE	100%	LUMP SUM
Contingent				
1. WILLIAM DOE 2034 DARLEN AVE. APT 201A HINESVILLES GA US 54321		FATHER	100%	36 MONTHS

I HAVE READ AND UNDERSTAND the instructions on pages 2 and 3 of this form. I ALSO UNDERSTAND that:

- **This form cancels any prior beneficiary or payment instructions.**
- The proceeds will be paid to beneficiaries as stated in #6 on page 3 of this form, unless otherwise stated above.
- If I have legal questions about this form, I may consult with a military attorney at no expense to me.
- I cannot have combined SGLI and VGLI coverages at the same time for more than $400,000.

SIGN HERE IN INK _____ Date: 20051220

(Your Signature. Do not print.)

Do not write in space below. For official use only.

WITNESSED AND RECEIVED BY:	RANK, TITLE OR GRADE	ORGANIZATION	DATE RECEIVED

SGLV-8286 (E)